DRAFT

WIC Futures Study Group
Regionalization SubCommittee

October 19, 2010
Holiday Inn Conference Center
22 North Last Chance Gulch, Helena, MT

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Introduction

In response to financial, structural, and operational challenges within the Montana Women, Infants, and Children (WIC) nutritional program, the WIC Futures Study Group was convened to evaluate and revise the WIC service delivery system to provide effective, efficient, and high quality services to the greatest number of participants possible.

The tenth meeting of the group was held on Tuesday, October 19, 2010. The following is a report of the meeting activities.

Participants included:

Mary Beth Frideres	MPCA	Peggy Stevens	Mineral County HD
Joan Bowsher	DPHHS/WIC	Bill Hodges	Big Horn County HD
Mark Walker	DPHHS/WIC	Jillian Brown	Lewistown HRDC
Carrie Reynolds	DPHHS/WIC	Kathleen Jensen	Sheridan County HD
Jane Smilie	DPHHS/WIC (afternoon)		
Linda Best	Deer Lodge/Beaverhead County WIC		

The meeting was facilitated by Mary Beth Frideres of the Montana Primary Care Association. The desired outcomes for the session were as follows:

By the end of this session, participants will have –
- Reviewed survey information
- Identified options and detailed options for future service delivery
- Identified level of support from committee members on each option
- Determined what comes next.

Opening Comments

Opening comments were made by Joan Bowsher, DPHHS WIC Director. Joan talked about the topic of regionalization. She said the current model has everything from pass-through funds to lead agencies that divide the money up for satellites. We really don't have standardization or true regionalization. Local agencies have all sorts of staffing. They may be open 1 day a month or a half a day every three months. That is an expensive way to do business because of the cost of keeping staff trained on providing a good service, computer use, etc. The state office does not want to go back to 50 contracts but a few more would be ok. What should a region look like? What

services should be offered? There is some money available for good ideas. Some states are purchasing kiosks that are located in the waiting rooms. That is where the patient receives follow up education. There have been some areas where money is being saved – not as many monitoring visits are necessary, for example. Due to the new computer system, 80% of the monitoring is now done from the Helena office. There are some clinics that are now offering three months worth of checks but others are still not doing that. Joan hopes we can come up with some good recommendations that would work for small and large counties.

Introductions were then made. Mary Beth asked the group if they wanted to proceed as several committee members were unable to be present at the meeting. The group, some of whom had travelled many miles, said they wanted to go forward with the meeting. The group reviewed the agenda.

Review of Survey Information

Linda Best reviewed the survey document, "WIC Agency Structure Survey" the participants had in the meeting packet, as well as some comments that had come in after the packet was created. The document was made up of comments elicited from representatives from the WIC clinics across the state. The results seemed to show a split of 6 for and 6 against and 2 undecided for regionalization.

Linda said she was initially against the concept of regionalization – or consolidation, she said, a word that feels less inflammatory. In looking back over the years, Linda said, financing has not changed and costs have gone up resulting in her concluding that, "We have to change the way we do business." If we want to serve the most people and give the best service, we cannot further divide the money. We must look to the future and recommend how to make the whole better. The state must also look at ways to be more efficient. What do we want WIC to be? We need to figure that out and then drive in that direction. Members of the group talked about how the program was set up to try to get services into all Montana counties, ideally working with health departments. But that did not always work well due to limited public health services in some counties.

Joan talked about some of the inefficiencies. She gave the example of one program is eastern Montana that is open for WIC 2 days per month. They sent three people to training in Helena. It took a day to drive here and a day to drive back. That type of management is very expensive. But the ones who do not get to go to training miss out responded a committee member.

Several participants noted that they provide a substantial amount of "in-kind" support, essentially subsidizing the WIC program with employee time or other resources. There are instances where county commissioners have said they will not give county money to the WIC program. One participant noted that the lead agency funding does nothing for her program. Several mentioned there is growing concern about being able to offer good wages and the comment was made more than once that there are agencies willing or wanting to give up the WIC program because of these concerns. "If that happens, it may be difficult to find someone to take it," said one participant.

Joan said that if the group decides to reduce the number of regions, what would happen, most likely, is that an RFP (Request for Proposals) would be developed and many different entities would be able to apply. There was support from several group members for that process. "Everyone could come up with ideas and apply equally," said Kathy Jensen.

Mark suggested that the group really look at costs. He noted that there is no way to change the amount of money the state gets unless many more clients are served or there are negotiations with the feds. What is the real cost of training and travel? If services are centrally located in an area, travel to services costs go up while training costs for staff may go down. Peggy noted that she has experienced effects of regionalization through other programs and that it is her feeling that some communities "get the short end of the stick." We should focus, she said, on getting services to the people. Kathy agreed. "Maybe it is best to just give everyone their own money." was suggested.

Linda said she didn't think there was enough money to go around as it is. Computer training costs more, for example, and we must meet federal regulations – that costs money. Giving money to each county doesn't work. Some counties don't have any infrastructure. With public health improvement efforts, we may eventually have to be accredited to qualify for any money, she added.

Bill offered an idea for cost control – can training be done by webinar? Joan said yes. Two training days per year are required. One is offered during the Public Health conference and one is about the changes in the regulations which could be over webinar. Currently, all of the regions have been asked to send one person to training and then that person should go back and train others.

Jillian said there should be more consolidation. She offered some observations on the maps provided. Mark wondered if consolidation would really save money – would the net hours change? He said he could see some savings in training costs. Jillian asked if RD time could be shared by more programs and noted that would be a cost savings. Mark said, for a small clinic, the person who works WIC must have another job. Bill agreed. That is how it works at his site, if a client does not show up, the person works on other things.

Mark asked the group what it would be like to imagine the state as one region. He gave current examples where one WIC agency helped others and suggested that level of cooperation could be available now. You would have the flexibility to move resources around. Linda said she didn't think that would work because "someone has to pay." For example, if lots of people show up, someone has to alter what happens on the local level. You can't just increase another employee's hours because there is only so much money. You are always "robbing Peter to pay Paul." Linda believes that with more consolidation, efforts can be maximized. Locally, there would be more clients and more money to work with.

There was discussion about the current system and how it seems to be unfair. Some clinics charge expensive rent to WIC. Some use WIC funds to supplement indirect cost allocation plans. How do we get the most efficient system without regionalization? Someone in the group suggested that the State WIC program hire all of the program's FTEs and assume the cost. Joan did not think that would be possible as the Department is restricted in hiring staff.

Kathy asked Joan about what is done in other states. Joan talked about South Dakota and Wyoming where all program staff are state employees and they contract for clinical administrative support. The group discussed the pros and cons of one entity applying for and operating the WIC program across the state as could happen in an RFP application. In any scenario, services on Indian reservations should be handled separately, Joan suggested.

Peggy asked what happens historically if small clinics close – does participation go down? Joan said it does at first, but then picks up as clients learn that they must travel to a more central location. Some clients like the anonymity a larger clinic offers over a small town. Over time, participation surpasses the former numbers. The group discussed catchment areas where people go to do other things like shopping for clothes, supplies, or groceries – services could offered in those communities. Clients still have to drive to get there, said Kathy.

One participant said sending out checks works just fine. Other ideas the group has had during the past two years are being implemented sporadically across the state.

Structural Options for Service Delivery and What Each Options Looks Like

The group came up with three options and thought through what each option would look like. The following is a summary of that process:

Options for WIC Service Delivery 2014

1. **Further Consolidation**
    a. Maybe break up large areas and consolidate smaller ones

b. Efficiency may improve
c. May be based on participation, i.e., x number of participants per FTE - may not take in geography
d. Look where people go to shop for food – offer services there – criteria that matter and cross over decisions – option may be out of state like Williston, ND
e. Get more checks less often – can issue up to three months of benefits but must go to store at least 1x/month. - EBT will give more flexibility in purchasing benefits; for example, can buy all food at once.
f. Education can be offered in many ways – mail, flyers, kiosks, etc. – doesn't have to be face to face
g. Impact will be on service and number of participants but don't know right now
h. Might see fewer satellites – a cost saving point of view would be to not serve communities with less than 30-50 participants – might serve in a different way, i.e., set up at Walmart or other catchment site, may only have WIC appointment 2x/year
i. Transportation issues may increase
j. In 2014, it will be clear who has what authority – don't know now who is the enforcer – need parameters and guidelines for clarity
k. RFP is a great idea to move change
l. May decrease in-kind contributions
m. We will have an increased reliance on information technology – costs would come down if clinics bought their own computers/internet services (approximately $1600/computer and internet service) – could also save if one laptop is carried to several locations instead of a computer in each location
n. State decides regions, sets guidelines, $X per participant then put out an RFP

2. Keep everything the same
a. State funding base will continue to be status quo
b. There will be 10% growth in participation by 2014 which will occur mostly in more populated communities
c. This could mean a 12% reduction in local funds for WIC due to 3% increases in salary cost per year
d. There will be more retirements which will lead to staff changes and salaries will decrease when new people come on
e. May have trouble filling positions with qualified applicants
f. IT infrastructure costs will increase and on the state and local level
g. There will be a reduction in outreach clinics in outlying areas
h. More revisions for SPIRT system
i. Fewer people in rural areas will access services because hours will be cut back
j. Will have to use more technology like Skype and kiosks to make it work which will mean more IT staff
k. EBT will be implemented – if online system, changes in benefits can be implemented automatically to the card, if offline, must have client come into clinics to make changes
l. Transportation costs will increase which will affect both participants and staff
m. EBT will mean it will be more costly to work with vendors
n. Accreditation of Public Health Departments may impact funding
o. Public Health program funding may be addressed less categorically with one contract for everything
p. Working poor will increase and they may be just a little over the eligibility level for WIC. They are the ones who have to pay for formula, as well.
q. Feds say the money is good through 2012 then may get tight again
r. Increasing levels of frustration about subsidizing WIC
s. Montana population trending – east is losing population elderly remaining – west is gaining population

3. Keep same system but add efficiency methods – The group realized after going through the exercise that the state could require efficient methods of service be carried out by agencies. This intermediate step may result in savings that could help the program.

What Should We Do Next?

The facilitator noted that it felt like the group "had been here before." She asked each committee member that was not an employee of the state, "What should be the next step? Where does this committee go from here?" Here are their comments:

- Need a cost effective program - access should not be more difficult for some - willing to look at combination of approaches

- Want the system to be fair geographically

- Need a different way to be a provider of WIC - we are asking the same questions and don't get anywhere

- Do an RFP/let people be committed - they agree to take it on

- Send some members to other states - like the RFP - put incentives for frontier areas in or you won't have any contractors

- Have seen some progress - looking to the future - more willing to change than before everyone started to think we need to do something - people who have expertise are more efficient/look at regional dieticians, LARCs, breast-feeding coordinator - some areas are doing regionalization well - like the use of technology and should put that into the mix - we have some pieces but need more info – What does it cost per participant? What should it cost? Have asked for data on the potential eligibles per county and feedback on how we are doing but don't have it - like pilot projects - willing to work some of the bugs out in my clinic

The facilitator noted that the Study Group has been very successful. People are implementing suggested changes. Group members have provided a lot of input into how the program should be administrated.

It was suggested that it may be time for the state WIC program administrators to take the principles the group developed, successful approaches from other states, and the ideas brought forward through the Study Group and use them to outline a cost effective program. One participant said problems have occurred because the state does not enforce what needs to be done. The group discussed the RFP option and felt it would be helpful to facilitate needed changes in the WIC program. You could set it up the way it should be and then organizations could apply according to the new rules. "It may be the only way to really change the program," another person offered.

Recommendations from the Regionalization Subcommittee to the WIC Study Group

The following is a summary of the group's recommendations:

1. The State WIC program should look at state data (like cost per participant, potential eligibles), ideas from the Study Group, and what has been tried and learned in other states and come up with a plan to move the program forward in the most cost efficient way possible.
2. The State WIC program should develop requirements for service approaches and actions.
3. The State WIC program should develop an RFP process for WIC to be implemented in 2013, including options for consolidation/regionalization and incentives for cost effective service delivery. Innovation should be encouraged.
4. Set a meeting mid February 2011 with the whole Study Group to review and discuss these recommendations and decide which ones should go to the State. The State WIC program should present possible components of a WIC RFP to the Study Group during this meeting and get input.
5. The mission and principles the Study Group developed should be included in the report of this meeting.

Evaluation

In regard to what participants liked about the meeting, several participants liked the discussion that took place. One person said it felt like we hit a wall and we need to get over the hurdle. Another thought the group got farther than they expected and that prompted one participant to state that the group accomplished what it came here to do with a lot of great work. One person said it was important to have a facilitator at these meetings and another person said that it was good that we were able to "change horses in the middle of the road." One participant said there was robust discussion and they were glad we took the time to hear everyone. A person who came in late thanked the group for getting her "up to speed." She noted that the Study Group has already brought the WIC program forward in a positive way and reminded the group that when it started, the program audit was "in the dumpster" and it had a DOS based computer system. One participant said there was no bloodshed and lots of open-mindedness. We had to go through all of that to get to a point where it became clear what needed to be done, added another. Several group members mentioned how difficult the subject is but noted that it must be addressed. One person appreciated the 2013 date and felt that would give the larger group time to "chew on it." Another mentioned the good input from everyone and the "lack of hostility was amazing."

As to what should be changed or done differently in future meetings, one person mentioned that it would have been better to have a more focused idea of what we were trying to accomplish. Another person noted that the tribal piece "was missing" and that is a key component of any plan. One person laughingly added that she wished that "someone else would take on these assignments."

Public Comment

No members of the public were present at the meeting.

Attachment

The WIC Mission, Study Group Task, WIC Principles, and WIC Shared Vision are attached.

Montana WIC Mission

To improve the nutritional status of eligible pregnant and breastfeeding women, infants, and children up to age 5, by providing nutritional education, referrals, and nutritious supplemental food.

WIC Futures Study Group Task

The WIC Futures Study Group was convened to evaluate and revise the WIC service delivery system to provide effective, efficient, and high quality services to the greatest number of participants possible.

Montana WIC Guiding Principles

Service delivery will be focused on the client.
Communication will be open and honest at all levels.
WIC is a partnership of client, staff, vendors, and the state office.
The Montana WIC Program decisions are based on measurable objectives, quality standards, and cost-effective considerations.
WIC services will be planned and delivered in way that decreases disparities due to race, geography, and ethnicity.
WIC strives to improve the health status of the eligible population to the greatest extent possible with the resources that are available.
WIC embraces new technology and innovative ideas to improve service delivery.

Our Shared WIC Vision

WIC is a quality nutrition education and supplemental food program that promotes breastfeeding and makes measurable improvements in the health of women, infants, and children.

WIC has a great reputation for being client –focused, accessible, innovative, flexible, and future-oriented.

Well-trained staff create a non-threatening environment in which individual needs are respected and families come to get help and receive referrals.

WIC is a well-managed, cost-effective public health program that is fully funded, and uses a Quality Improvement Model.

WIC is known for being proactive in problem resolution, clear communication, and working well with all partners.